

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

FILED OCT 29 1957

State File No. **37695**
Registrar's No. **9803**

BIRTH NO. _____		REG. DIST. NO. 318		PRIMARY REG. DIST. NO. 1003		State File No. 37695		Registrar's No. 9803			
1. PLACE OF DEATH a. COUNTY _____					2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission). a. STATE Missouri b. COUNTY _____						
b. CITY (If outside corporate limits, write RURAL and give township) OR TOWN St. Louis			c. LENGTH OF STAY (in this place) _____		c. CITY OR TOWN St. Louis		d. Is Residence within limits of a city or incorporated town? Yes <input type="checkbox"/> No <input type="checkbox"/>				
3. FULL NAME OF HOSPITAL OR INSTITUTION St. Louis State Hospital					e. STREET ADDRESS (If rural, give location) 3834 Kingsland Court						
3. NAME OF DECEASED (Type or Print) a. (First) Andrew		b. (Middle) R.		c. (Last) Kleekamp Sr.		4. DATE OF DEATH (Month) (Day) (Year) Oct. 17, 1957					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify) Married		8. DATE OF BIRTH 1898 Oct. 25, 1898		9. AGE (In years last birthday) 58 If UNDER 1 YEAR: Months _____ Days _____ If UNDER 1 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Western Union Clerk			10b. KIND OF BUSINESS OR INDUSTRY _____			11. BIRTHPLACE (City and State or Foreign Country) St. Louis, Missouri			12. CITIZEN OF WHAT COUNTRY? USA		
13a. FATHER'S NAME Joseph Kleekamp			13b. MOTHER'S MAIDEN NAME Bernadine Fleiter			14. NAME OF HUSBAND OR WIFE Carrie					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16. SOCIAL SECURITY NO. 493-03-0026			17. INFORMANT'S SIGNATURE OR NAME ADDRESS Carrie Kleekamp 3834 Kingsland Ct.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		MEDICAL CERTIFICATION I. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) Acute coronary thrombosis ANTECEDENT CAUSES DUE TO (b) Hypertension DUE TO (c) _____ II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes						INTERVAL BETWEEN ONSET AND DEATH 420.1			
19a. DATE OF OPERATION _____		19b. MAJOR FINDINGS OF OPERATION _____						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT SUICIDE HOMICIDE (Specify) _____		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21c. (CITY, TOWN, OR TOWNSHIP) _____ (COUNTY) _____ (STATE) _____							
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) _____		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? _____							
22. I hereby certify that I attended the deceased from May 7, 1951 , to October 17, 1957 , that I last saw the deceased alive on October 17, 1957 , and that death occurred at 3:45 a.m. , from the causes and on the date stated above.											
23a. SIGNATURE R. K. Kleekamp M.D.				(Degree or title) _____				23b. ADDRESS 5100 Arsenal Street		23c. DATE SIGNED 10-17-57	
24a. BURIAL, CREMATION, REMOVAL (Specify) Removal		24b. DATE 10-19-57		24c. NAME OF CEMETERY OR CREMATORY Mt. Olive		24d. LOCATION (City, town, or county) (State) Lemay 23, Mo.					
DATE REC'D BY LOCAL REG. OCT 21 57		REGISTRAR'S SIGNATURE Carrie Kleekamp				25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Southern Funeral Home 6322 S. Grand, St. Louis, Mo.					

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USING UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.....
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

Harold Van Housen

Licensed Embalmer No. *4282*

P. O. Address *St. Louis, Mo.*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.